		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021238

Facility Name: P A Peterson Center for Health

Address: 1311 Parkview Ave. (Number) Rockford, Illinois (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 399-8832 **Fax #** (815) 399-8342

IDPA ID Number: 36-2584799-004

Date of Initial License for Current Owners: 1941

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Dorkas Cruz **Telephone Number:** (847) 635-4633

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 172

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	44,384	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	52	Sheltered Care (SC)	52	18,980	5
6		ICF/DD 16 or Less			6
7	172	TOTALS	172	63,364	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,499	8,499	8
9	SNF/PED					9
10	ICF	7,322	21,434		28,756	10
11	ICF/DD					11
12	SC		6,590		6,590	12
13	DD 16 OR LESS					13
14	TOTALS	7,322	28,024	8,499	43,845	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.20%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N/A]

I. On what date did you start providing long term care at this location?
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 8,499

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number P A Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	326,460	26,612	28,364	381,436		381,436		381,436			1
2	Food Purchase		254,121		254,121		254,121	(8,677)	245,444			2
3	Housekeeping	130,362	28,997	1,479	160,838		160,838		160,838			3
4	Laundry		27,287	139,965	167,252		167,252		167,252			4
5	Heat and Other Utilities			176,921	176,921	2,920	179,841	(10,439)	169,402			5
6	Maintenance	119,995	34,940	98,892	253,827	2,291	256,118		256,118			6
7	Other (specify):* Rubbish/Medical Removal			11,218	11,218	925	12,143		12,143			7
8	**TOTAL General Services**	576,817	371,957	456,839	1,405,613	6,136	1,411,749	(19,116)	1,392,633			8
	B. Health Care and Programs											
9	Medical Director			18,337	18,337		18,337		18,337			9
10	Nursing and Medical Records	2,660,057	326,522	12,270	2,998,849		2,998,849		2,998,849			10
10a	Therapy			524,093	524,093		524,093		524,093			10a
11	Activities	77,058	4,756		81,814		81,814		81,814			11
12	Social Services	103,874		1,323	105,197		105,197		105,197			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,840,989	331,278	556,023	3,728,290		3,728,290		3,728,290			16
	C. General Administration											
17	Administrative	68,430			68,430	225,325	293,755		293,755			17
18	Directors Fees											18
19	Professional Services			585,447	585,447	(417,758)	167,689	166,534	334,223			19
20	Dues, Fees, Subscriptions & Promotions			31,391	31,391	24,656	56,047	(11,180)	44,867			20
21	Clerical & General Office Expenses	147,691	29,875	51,283	228,849	45,983	274,832		274,832			21
22	Employee Benefits & Payroll Taxes			704,528	704,528	16,793	721,321		721,321			22
23	Inservice Training & Education					3,675	3,675		3,675			23
24	Travel and Seminar			9,023	9,023		9,023		9,023			24
25	Other Admin. Staff Transportation					5,686	5,686		5,686			25
26	Insurance-Prop.Liab.Malpractice			23,364	23,364	15,313	38,677		38,677			26
27	Other (specify):* Fund Raising					4,004	4,004	(4,004)				27
28	**TOTAL General Administration**	216,121	29,875	1,405,036	1,651,032	(76,323)	1,574,709	151,350	1,726,059			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,633,927	733,110	2,417,898	6,784,935	(70,187)	6,714,748	132,234	6,846,982			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number P A Peterson Center for Health #0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			374,561	374,561	30,347	404,908	761	405,669			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			235,412	235,412	7,018	242,430		242,430			32
33	Real Estate Taxes			126,836	126,836	184	127,020		127,020			33
34	Rent-Facility & Grounds					26,979	26,979		26,979			34
35	Rent-Equipment & Vehicles			26,809	26,809	5,659	32,468		32,468			35
36	Other (specify):*											36
37	**TOTAL Ownership**			763,618	763,618	70,187	833,805	761	834,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,339	66,339		66,339		66,339			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			66,339	66,339		66,339		66,339			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,633,927	733,110	3,247,855	7,614,892		7,614,892	132,995	7,747,887			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,677)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,439)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,262	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(11,180)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	158,611			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 136,577		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(3,582)	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (3,582)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 132,995		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

P A Peterson Center for Health

ID# 0021238

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjust out Advertising & Promotions- Mgmt	$ (3,661)	27	1
2	Adjust out Advertising & Promotions-Serv Network	(343)	27	2
3	Adjust Allowable Mgmt & HR allocation	78,984	19	3
4	Adjust Allowable Service Network Allocation	87,550	19	4
5	Adjust Out Management auto depreciation	(1,487)	30	5
6	Programs Auto (over one limit)	(2,432)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	158,611		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number P A Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,677)	0	0	0	0	0	0	0	0	0	0	(8,677)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,439)	0	0	0	0	0	0	0	0	0	0	(10,439)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(19,116)	0	0	0	0	0	0	0	0	0	0	(19,116)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	166,534	0	0	0	0	0	0	0	0	0	0	166,534	19
20	Fees, Subscriptions & Promotions	(11,180)	0	0	0	0	0	0	0	0	0	0	(11,180)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,004)	0	0	0	0	0	0	0	0	0	0	(4,004)	27
28	**TOTAL General Administration**	151,350	0	0	0	0	0	0	0	0	0	0	151,350	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	132,234	0	0	0	0	0	0	0	0	0	0	132,234	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number P A Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	761	0	0	0	0	0	0	0	0	0	0	761	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	761	0	0	0	0	0	0	0	0	0	0	761	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	132,995	0	0	0	0	0	0	0	0	0	0	132,995	45

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Vesper Mgmt Corp	Des Plaines Illinois	Mgmt Co.
N/A		N/A	N/A	LSSI	Des Plaines Illinois	Corp. Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: ((847) 635-4600
Fax Number: ((847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	25,992,212	270	$ 1,125,505	$ 1,125,505	2,114,626	$ 91,567	1
2	22	Empl Benefits & Taxes		25,992,212	270	(144,917)		2,114,626	(11,790)	2
3	19	Prof Fees & Contracts		25,992,212	270	3,524,353		2,114,626	286,728	3
4	21	Supplies, Telephone		25,992,212	270	490,475		2,114,626	39,903	4
5		Postage, Out. Printing		25,992,212	270	0		2,114,626	0	5
6	34	Rental of Space		25,992,212	270	318,277		2,114,626	25,894	6
7	5	Utilities		25,992,212	270	35,381		2,114,626	2,878	7
8	6	Bldg Repairs & Maintenance		25,992,212	270	984		2,114,626	80	8
9	32	Interest		25,992,212	270	80,208		2,114,626	6,525	9
10	33	Real Estate Taxes		25,992,212	270	2,265		2,114,626	184	10
11	26	Insurance		25,992,212	270	186,098		2,114,626	15,140	11
12	27	Advertising & Promotions		25,992,212	270	44,994		2,114,626	3,661	12
13	25	Transportation		25,992,212	270	40,592		2,114,626	3,302	13
14	35	Car Rental		25,992,212	270	537		2,114,626	44	14
15	23	Conferences & Conventions		25,992,212	270	30,389		2,114,626	2,472	15
16	20	Subscriptions, Dues, Awards		25,992,212	270	32,258		2,114,626	2,624	16
17	21	Furniture & Fixtures		25,992,212	270	463		2,114,626	38	17
18	6	Machinery & Equipment		25,992,212	270	378		2,114,626	31	18
19	35	Equipment Rental		25,992,212	270	53,376		2,114,626	4,342	19
20	6	Equipment Repair & Maint		25,992,212	270	23,734		2,114,626	1,931	20
21	20	Employee Recruitment		25,992,212	270	0		2,114,626	0	21
22	7	Security & Waste Removal		25,992,212	270	11,369		2,114,626	925	22
23	21	All Other Miscellaneous		25,992,212	270	5,351		2,114,626	435	23
24	30	Depreciation		25,992,212	270	346,548		2,114,626	28,194	24
25	TOTALS					$ 6,208,618	$ 1,125,505		$ 505,108	25

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: ((847) 635-4600
Fax Number: ((847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	46,042,289	244	$ 928,620	$ 928,620	4,338,456	$ 87,502	1
2	22	Empl Benefits & Taxes		46,042,289	244	144,251		4,338,456	13,592	2
3	19	Prof Fees & Contracts		46,042,289	244	139,400		4,338,456	13,135	3
4	21	Supplies, Telephone		46,042,289	244	31,083		4,338,456	2,929	4
5		Postage, Out. Printing		46,042,289	244			4,338,456		5
6	34	Rental of Space		46,042,289	244	4,380		4,338,456	413	6
7	5	Utilities		46,042,289	244	445		4,338,456	42	7
8	6	Bldg Repairs & Maintenance		46,042,289	244	430		4,338,456	41	8
9	32	Interest		46,042,289	244	5,232		4,338,456	493	9
10	33	Real Estate Taxes		46,042,289	244			4,338,456		10
11	26	Insurance		46,042,289	244	1,831		4,338,456	173	11
12	27	Advertising & Promotions		46,042,289	244			4,338,456		12
13	25	Transportation		46,042,289	244	14,762		4,338,456	1,391	13
14	35	Car Rental		46,042,289	244	4,457		4,338,456	420	14
15	23	Conferences & Conventions		46,042,289	244	8,462		4,338,456	797	15
16	20	Subscriptions, Dues, Awards		46,042,289	244	173,188		4,338,456	16,319	16
17	21	Furniture & Fixtures		46,042,289	244	145		4,338,456	14	17
18	6	Machinery & Equipment		46,042,289	244			4,338,456		18
19	35	Equipment Rental		46,042,289	244	8,743		4,338,456	824	19
20	6	Equipment Repair & Maint		46,042,289	244	2,211		4,338,456	208	20
21	20	Employee Recruitment		46,042,289	244	58,673		4,338,456	5,529	21
22	7	Security & Waste Removal		46,042,289	244			4,338,456		22
23	21	All Other Miscellaneous		46,042,289	244	375		4,338,456	35	23
24	30	Depreciation		46,042,289	244	13,468		4,338,456	1,269	24
25	TOTALS					$ 1,540,156	$ 928,620		$ 145,126	25

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: ((847) 635-4600
Fax Number: ((847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	3,854,050	2	$ 84,305	$ 84,305	2,114,626	$ 46,256	1
2	22	Empl Benefits & Taxes		3,854,050	2	27,323		2,114,626	14,991	2
3	19	Prof Fees & Contracts		3,854,050	2	917		2,114,626	503	3
4	21	Supplies, Telephone		3,854,050	2	2,086		2,114,626	1,145	4
5		Postage, Out. Printing		3,854,050	2			2,114,626		5
6	34	Rental of Space		3,854,050	2	1,224		2,114,626	672	6
7	5	Utilities		3,854,050	2			2,114,626		7
8	6	Bldg Repairs & Maintenance		3,854,050	2			2,114,626		8
9	32	Interest		3,854,050	2			2,114,626		9
10	33	Real Estate Taxes		3,854,050	2			2,114,626		10
11	26	Insurance		3,854,050	2			2,114,626		11
12	27	Advertising & Promotions		3,854,050	2	625		2,114,626	343	12
13	25	Transportation		3,854,050	2	1,809		2,114,626	993	13
14	35	Car Rental		3,854,050	2	53		2,114,626	29	14
15	23	Conferences & Conventions		3,854,050	2	740		2,114,626	406	15
16	20	Subscriptions, Dues, Awards		3,854,050	2	335		2,114,626	184	16
17	21	Furniture & Fixtures		3,854,050	2			2,114,626		17
18	6	Machinery & Equipment		3,854,050	2			2,114,626		18
19	35	Equipment Rental		3,854,050	2			2,114,626		19
20	6	Equipment Repair & Maint		3,854,050	2			2,114,626		20
21	20	Employee Recruitment		3,854,050	2			2,114,626		21
22	7	Security & Waste Removal		3,854,050	2			2,114,626		22
23	21	All Other Miscellaneous		3,854,050	2	2,704		2,114,626	1,484	23
24	30	Depreciation		3,854,050	2	1,611		2,114,626	884	24
25	TOTALS					$ 123,732	$ 84,305		$ 67,890	25

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993 Bond Refinancing		X	Refinance Mortgage	N/A	9/23/93	$ 1,991,385	$ 3,360,006	08/15/01	7.3800	$ 235,412	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation per Sch VIII	X		Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	7,018	6
7												7
8												8
9	TOTAL Facility Related						$ 1,991,385	$ 3,360,006			$ 242,430	9
	B. Non-Facility Related*											
10	N/A			N/A	N/A	N/A	N/A	N/A	N/A	N/A		10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,991,385	$ 3,360,006			$ 242,430	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ N/A** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number P A Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 129,263	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 126,348	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,915)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 129,751	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 126,836	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	127,393	8
	1998	128,667	9
	1999	127,680	10
	2000	126,110	11
	2001	126,586	12

Line 2: Payment of $ 126,348 represents a $ 63,055 for 2000 and $ 63,293 for 2001

Line 4: Accrual of $129,751 is based on second half of 2001 of $ 63,293 and estimated first half of 2002 of $ 66,458

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P A Peterson Center for Health COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT Dorkas Cruz

TELEPHONE (847) 635-4633 FAX #: (847) 635-6764

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	163B-600 12-19-101-001	3 Stories, Steel Grids, Masonry	$ 126,586.22	$ 126,586.22
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 126,586.22	$ 126,586.22

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	192,020	1985	$ 8,455	1
2					2
3	TOTALS	192,020		$ 8,455	3

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	172		1942	1942	$ 95,858	$	50	$	$	$ 95,858	4
5			1979	1979	5,596,922	139,923	40	139,923		3,218,614	5
6											6
7											7
8											8
	Improvement Type**										
9	1944 Addition			1944	50		50			50	9
10	1948 Addition			1948	157		50			157	10
11	New roof			1969	2,119		25			2,119	11
12	Boiler			1969	5,300		20			5,300	12
13	Ground Improvements			1971	2,400		15			2,400	13
14	New doors			1973	4,326		28			4,326	14
15	Electric Alarm System			1974	2,056		15			2,056	15
16	1975 Addition			1975	9,226		20			9,226	16
17	Remodeling			1977	10,074		16			10,074	17
18	Addition to Bldg			1980	2,874	74	39	74		1,622	18
19	Grab Bars			1982	6,151		10			6,151	19
20	Automatic Door Controls			1983	10,386		10			10,386	20
21	Remodel Suites to singles			1983	20,550		10			20,550	21
22	Screen patio Cover			1984	1,205		10			1,205	22
23	32 Storm Windows			1984	2,080		10			2,080	23
24	Convert Suites to Rooms			1984	11,900		10			11,900	24
25	Remodel Suites to singles			1986	15,800		10			15,800	25
26	New Drop Ceiling			1991	750		10			750	26
27	Repair Damaged Roof			1993	4,296	430	10	430		3,653	27
28	Second Floor Redecoration			1994	89,701	8,970	10	8,970		76,111	28
29	Adjustment per IDPA 2nd Flr Decorating			1994	(2,730)		10	(273)	(273)	(2,321)	29
30	Floor Cleaning Equipment			1979	1,360		10			1,360	30
31	Electrical Work			1980	726		10			726	31
32	Painting			1980	3,253		10			3,253	32
33	Carpenting			1980	5,076		10			5,076	33
34	Landscaping			1980	69,073		10			69,073	34
35	Landscaping - Final 1980			1981	7,309		10			7,309	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Nurse call system- Basement	1983	$ 1,700	$	10	$	$	$ 1,700	37
38	Carpeting	1984	1,503		10			1,503	38
39	Nurse Call Control Board	1984	2,900		10			2,900	39
40	Sprinkler System	1984	3,654		10			3,654	40
41	Paving	1985	4,850		10			4,850	41
42	Electrical Wall Fixtures	1985	6,605		10			6,605	42
43	Deluxe Tub with Lift	1986	5,840		10			5,840	43
44	Electrical Wall Fixtures	1986	6,575		10			6,575	44
45	2nd Floor Shower Room	1988	13,898		10			13,898	45
46	Improvements	1988	4,414		10			4,414	46
47	Improvements	1989	15,688		10			15,688	47
48	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS	1989	20,266		10			20,266	48
49	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS	1989	35,052		10			35,052	49
50	New Compressor	1989	1,272		7			1,272	50
51	Call Devices	1990	1,400		10			1,400	51
52	New Roof	1990	41,995	1,680	25	1,680		21,000	52
53	Public Address System	1990	4,200		5			4,200	53
54	First Floor Remodeling	1990	62,210	2,488	25	2,488		28,627	54
55	ADJUSTMENT PER IDPA- 1990 1rst Flr Remodeling	1990	(3,590)		25	(144)	(144)	(1,795)	55
56	Parker Bath Tub	1991	9,390		7			9,390	56
57	Cubical Curtains	1991	1,075		7			1,075	57
58	Laundry Room Remodeling	1991	2,082	16	10	16		2,082	58
59	Third Floor Remodeling	1992	99,312	4,952	10	4,952		99,312	59
60	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1992	(78,784)		10	(3,939)	(3,939)	(78,784)	60
61	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1991	54,938		10			54,938	61
62	Underground Fual Tank	1993	10,523		5			10,523	62
63	Security Cameras	1993	3,496		5			3,496	63
64	Bath Tub	1995	3,766	377	10	377		2,501	64
65	Parking lot	1995	16,425	657	25	657		4,273	65
66	IDPH Remodeling	1995	162,992	16,299	10	16,299		106,012	66
67	New Subacute Unit	1995	677,548	27,102	25	27,102		176,274	67
68	ADJUSTMENT PER IDPA 1995 Improvement to Equipment	1995	(63,067)	(4,505)	25	(4,505)		(63,067)	68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,108,376	$ 198,463		$ 194,107	$ (4,356)	$ 4,090,538	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,108,376	$ 198,463		$ 194,107	$ (4,356)	$ 4,090,538	1
2	Adjustment per IDPA - 1995 Improv to CORF	1995	(30,219)		25	774	774	(35,081)	2
3	Parking Lot # 94-502	1995	416	42	10	42		270	3
4	Carpet/Vinyl Dining Room	1995	12,220	1,222	10	1,222		7,945	4
5	Glass & Glazing for Door	1997	775	78	10	78		403	5
6	New Doors & Smoke Closet	1997	1,910	191	10	191		955	6
7	Floor Covering in Kitchen	1998	2,047	205	10	205		887	7
8	Repair Roof-P.A.P.	1998	53,433	2,137	25	2,137		8,549	8
9	Zoning Permit Parking Lot	1998	898	90	10	90		352	9
10	Planting & Mulch for P.A.	1998	7,186	719	10	719		2,813	10
11	Parking Lot Expansion	1998	778	78	10	78		305	11
12	North Parking Lot Remodeling	1998	80,391	8,039	10	8,039		31,474	12
13	Consulting N. Parking Lot	1998	806	81	10	81		309	13
14	Repair Conduit Damage	1998	3,982	398	10	398		1,426	14
15	Carpeting for Apartment C	1999	17,200	3,440	5	3,440		10,320	15
16	Office Partition PAP	1999	4,861	122	40	122		354	16
17	Corridor Ventilation Upgrade	2000	63,500	2,540	25	2,540		5,282	17
18	Plumbing	2001	2,963	296	10	296		592	18
19	Install Cumberland Print	2001	3,160	126	25	126		252	19
20	Windows	2001	10,000	400	25	400		799	20
21	Porch- Railings-Floors	2001	7,648	306	25	306		611	21
22	Roofing	2001	11,475	1,148	10	1,148		2,292	22
23	Porch- Railings-Floors	2001	13,612	544	25	544		1,087	23
24	Fan Coil Unit	2001	5,635	564	10	564		1,125	24
25	Contract Flooring-Interior	2001	2,920	117	25	117		213	25
26	Wall coverings	2001	2,990	120	25	120		219	26
27	Furniture	2001	36,175	1,447	25	1,447		2,644	27
28	Carpet-Furnish and instal	2001	1,095	44	25	44		80	28
29	Room Equipment Furniture	2001	4,372	175	25	175		305	29
30	Room Equipment Furniture	2001	687	27	25	27		48	30
31	Room Equipment Furniture	2001	1,245	50	25	50		87	31
32	Room Equipment Furniture	2001	840	34	25	34		59	32
33	Room Equipment Furniture	2001	1,123	45	25	45		78	33
34	TOTAL (lines 1 thru 33)		$ 7,434,500	$ 223,288		$ 219,706	$ (3,582)	$ 4,137,592	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,434,500	$ 223,288		$ 219,706	$ (3,582)	$ 4,137,592	1
2	Room Equipment Furniture	2001	5,878	235	25	235		410	2
3	Room Equipment Furniture	2001	550	22	25	22		37	3
4	Room Equipment Furniture	2001	2,534	101	25	101		160	4
5	Carpet Wallpaper	2001	12,410	1,241	10	1,241		1,853	5
6	Furnish and Install Carpet	2001	840	84	10	84		118	6
7	Electric work 3rd Flr Kitchen	2001	3,348	134	25	134		189	7
8	Renovation of Assisted Living	2001	880	35	25	35		38	8
9	Renovation of Assisted Living	2001	4,363	436	10	436		471	9
10	Renovation of Assisted Living	2001	2,129	85	25	85		85	10
11	Soft Start for Elevator	2001	7,466	745	10	745		745	11
12	Architectual Services	2001	2,958	118	25	118		118	12
13	HVAC System Revisions	2001	9,000	898	10	898		898	13
14	Rewire rooms 206 & 208	2001	975	36	25	36		36	14
15	Architectual Services	2001	2,338	85	25	85		85	15
16	Landscaping	2001	8,954	1,634	5	1,634		1,634	16
17	Furnish and Install Carpet	2002	1,068	88	10	88		88	17
18	Deposit To Start Kitchen	2002	3,531	292	10	292		292	18
19	Floor Improvements	2002	1,150	76	10	76		76	19
20	Furnitures & Fixtures Improvements	2002	19,528	1,263	10	1,289	26	1,289	20
21	Instalation of New Fire Place	2002	3,381	223	10	223		223	21
22	Architectual Services	2002	876	58	10	58		58	22
23	First Floor Construction	2002	35,000	1,701	10	1,725	24	1,726	23
24	Architectual Services	2002	1,962	97	10	97		97	24
25	2nd Floor Improvements	2002	2,500	49	25	49		49	25
26	Improvements Furnitures & Fixtures	2002	1,870	76	10	76		76	26
27	Instalation of New Fire place	2002	1,187	48	10	48		48	27
28	Labor cost for removing /Instaling A/C Compresor	2002	6,690	222	10	222		222	28
29	Renovation Architectural Time	2002	443	11	10	11		11	29
30									30
31									31
32	Management Assets- Security System	1999	9,258		10	32	32	N/A	32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,587,567	$ 233,381		$ 229,881	$ (3,500)	$ 4,148,724	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,340,554	$ 120,508	$ 156,373	$ 35,865	Various	$ 453,467	71
72	Current Year Purchases	194,285	18,243	19,415	1,172	Various	19,755	72
73	Fully Depreciated Assets	501,316				Various	501,316	73
74								74
75	TOTALS	$ 2,036,155	$ 138,751	$ 175,788	$ 37,037		$ 974,538	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	Handicapped Bus 1991	1991	$ 38,800	$	$	$	7	$ 38,800	76
77										77
78										78
79										79
80	TOTALS			$ 38,800	$	$	$		$ 38,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,670,977	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 372,132	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 405,669	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,537	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,162,062	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	95 Improvement CORF 1995	$ 30,219	$ 1,208	$ 7,855	86
87	96 Dodge Van 1997	17,032	2,432	13,034	87
88					88
89	Management Autos	7,115	1,487	N/A	89
90					90
91	TOTALS	$ 54,366	$ 5,127	$ 20,889	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 27,078 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N/A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		N/A					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number P A Peterson Center for Health # 0021238 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N/A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N/A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note: Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other asset and most liabilities in a complex, multi-funtional service agency.

Any Balance Sheet prepared with only those Assets with specific programs would not balance or present meaninful picture of that progrma's Financial Status.

*** This must agree with page 17, line 47.**

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,748,520	1
2	Discounts and Allowances for all Levels	(151,699)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,596,821	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,625	13
14	Non-Patient Meals	8,677	14
15	Telephone, Television and Radio	19,587	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	15,942	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 46,831	23
	D. Non-Operating Revenue		
24	Contributions	3,598	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,598	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		760	28
28a		(93)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 667	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,647,917	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,405,613	31
32	Health Care	3,728,290	32
33	General Administration	1,651,032	33
	B. Capital Expense		
34	Ownership	763,618	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	66,339	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,614,892	40
41	**Income before Income Taxes (line 30 minus line 40)****	33,025	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 33,025	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,648	1,947	$ 60,060	$ 30.85	1
2	Assistant Director of Nursing	12,895	14,375	197,416	13.73	2
3	Registered Nurses	29,925	33,365	664,002	19.90	3
4	Licensed Practical Nurses	42,302	46,508	741,060	15.93	4
5	Nurse Aides & Orderlies	75,627	82,179	891,270	10.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,673	6,480	75,222	11.61	9
10	Activity Assistants					10
11	Social Service Workers	3,528	4,010	56,827	14.17	11
12	Dietician					12
13	Food Service Supervisor	6,718	7,179	48,233	6.72	13
14	Head Cook	6,852	7,385	70,407	9.53	14
15	Cook Helpers/Assistants	25,790	27,704	207,819	7.50	15
16	Dishwashers					16
17	Maintenance Workers	7,306	8,205	119,995	14.62	17
18	Housekeepers	16,002	17,419	130,362	7.48	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,621	1,920	68,430	35.64	21
22	Other Administrative	2,022	1,931	34,590	17.91	22
23	Office Manager					23
24	Clerical	8,369	11,678	113,101	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,836	10,378	106,249	10.24	31
32	Other Health Care(specify)					32
33	Other(specify)	2,053	2,253	48,884	21.70	33
34	TOTAL (lines 1 - 33)	258,167	284,916	$ 3,633,927 *	$ 12.75	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 27,138	1,3	35
36	Medical Director	As Needed	18,337	9,3	36
37	Medical Records Consultant	As Needed	2,664	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	2,040	10,3	39
40	Physical Therapy Consultant	As Needed	398,056	10a,3	40
41	Occupational Therapy Consultant	As Needed	86,348	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	35,069	10a,3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) See Attached	As Needed	151,561	various	46
47	Legal & Audit/Accounting	As Needed	33,609	19,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 754,822		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	As Needed	1,045	10,3	52
53	TOTAL (lines 50 - 52)		$ 1,045		53

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy J. Holt	Administrator	0	$ 68,430
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,430

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal Fees	$ 2,930
Frost Ruttenberg and Roth	Medicare Consultant/Report Se	26,849
Transworld Systems INC	Collection Services	2,025
Joe Minerath	Medicare Cost Report Prep	1,511
IDPH	Legal Fees	147
IDPA	Legal Fees	147
LSSI	Management Services	551,838
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 585,447

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 145,996
Unemployment Compensation Insurance	33,583
FICA Taxes	260,446
Employee Health Insurance	270,782
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	(6,279)
Management Allocation Benefits	16,793
TOTAL (agree to Schedule V, line 22, col.8)	$ 721,321

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,389
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising & Promation, Awards, Grants	11,180
Subscriptions and Books	3,307
Membership Dues	14,104
Licenses & Fees	411
Management Allocation	24,656
Less: Public Relations Expense	( )
Non-allowable advertising	(11,180)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,867

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	3,424
Employee Milage Payments	4,756
Meals, Lodging	818
Seminar Expense	25
Conference & Conventions	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,023

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	N/A												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number P A Peterson Center for Health # 0021238 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network $ 4,340

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 16,285 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 66,339
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Yes Indicate the amount. $ 8,677

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____

c. What percent of all travel expense relates to transportation of nurses and patients? 0%

d. Have vehicle usage logs been maintained? Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Clifton Gunderson LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. In Progress, will send as soon as availa

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.